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ABSTRACT

Malcolm Bliss Mental Health Center, through the Outreach Service, provides psychiatric care for the residents of the Model Cities area of the City of St. Louis. The program was started three years ago, but was actually in full operation for about one and a half years. The services to children are a part of the total program and it is difficult to separate them without speaking about the rest of the program. The goals of the Outreach Services are: (1) to make mental health services easily accessible to all residents; (2) to establish programs with high-risk populations to prevent the development of psychiatric disabilities; and, (3) to educate neighborhood residents about mental health, psychiatric illness, and the various services available to them. In terms of these goals, five clinics were successfully established in five areas, and a higher percentage of the population there is being reached when compared to the rest of the catchment area. Some preventive programs have been started and work continues on the education of the neighborhood residents with some success. These programs are even more difficult to evaluate and only long-term studies will probably provide the answer about success or failure in this respect. One of the main obstacles to this work has been the low priority of mental health and mental disease for the poverty stricken residents of the inner city. (Author/JM)

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REACHING THE UNREACHED: A CHILDREN'S COMMUNITY MENTAL HEALTH PROGRAM IN THE INNER CITY

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For three years from its opening date on July 1, 1967, the Children's Unit of the Malcolm Bliss Mental Health Center (M.B.M.H.C.) in St. Louis, Missouri, carried on a full service program designed, it was thought, to meet the needs of the inner city area which surrounded the hospital. All of the requirements of a children's community mental health center were met. We offered in-patient and out-patient services, day care, 24 hour emergency service, consultation to the schools, juvenile courts, and welfare agencies. Families could come by appointment or they could just walk in. We were prepared, we thought, to do crisis intervention, family counseling, educational evaluations and remedial work, complete psychological evaluations, neurological work-ups, and a number of different psychiatric therapies. In addition, we became during that time an accredited training center for child psychiatrists. Being affiliated with Washington and Missouri Universities, we also helped to train social workers, psychologists, nurses and volunteers.

During the first 3 years, the initial response from the community was heartening. Between 1967 and 1970, we saw 2,423 children in our out-patient clinic. Between one-fifth and one-quarter of those were admitted to the in-patient service or day care. We were extremely busy and happy with our progress, until we began to look at the attrition rate.

In order to evaluate the clinic's functioning after 2 years, a sample of 390 children out of the first 1100 seen was studied in some detail. We found that approximately 75% of the children attended fewer than six times. One-third had only one visit, and 41% attended only 2 to 4 times. At the end of the two-year period, only one-quarter of the sample remained as active patients.

Our clinic orientation was toward short-term treatment. We prided ourselves on having no waiting list and no restrictions on referrals. However, we knew that

many of the children who were dropping out had serious problems that warranted longer periods of treatment than they were getting. We were forced to admit that their needs were not being met. The very factors which sent them in search of free mental health care also interfered with their attending the free clinic, namely: lack of transportation or bus fare, lack of babysitters for young siblings, mothers having to work, breakdown of family life, and in some cases, mental illness in the responsible person.

Another factor with which we were faced almost daily in our conversations with children whose mothers were brave enough to bring them to a mental hospital, was the persistent stigma attached to going to "Malcolm Bliss". For 30 years, the hospital had served the City of St. Louis as the Psychiatric Division of the City Hospital for short-term treatment of indigent residents until it became a Mental Health Center under the State of Missouri in 1964. In spite of the fact that it was designed as an acute treatment center and maintained an average length of stay for adult patients of only about 30 days, fears and adverse beliefs about the hospital were strong among the indigent patients it was intended to serve. Many mothers would bring their children to our clinic only under great pressure from outside agencies. A way of providing services which would somehow by-pass the problems of poverty and stigma was greatly needed.

A possible solution was found in 1969 when M.B.M.H.C. joined forced with the Model Cities Agency and established 5 neighborhood clinics in one of the most poverty-stricken areas of the city, out from under the shadow of the hospital. As most of you know, the Model Cities program is a federally funded effort to develop and use indigenous leadership in bettering the lives of people living in the degenerated "urban-blight" areas. The psychiatric clinics served both adults and children and were only one of the many facets of the

Model Cities program.

SPACE FOR MAP

Catchment Area

As shown on the map, the geographic area served by Malcolm Bliss Mental Health Center extends over a range of 15 to 20 miles west of the Mississippi River, on the north and northwestern section of St. Louis City and County. The rest of the territory shown lies in the catchment of the St. Louis State Hospital located in the south central section of the city. The Model Cities area covers only a small part of the inner city. Previously, the poor families from that area had to take a bus downtown and transfer to another bus to reach the hospital. The cost would be about $1.00 round trip for the mother and 50¢ for each child over five. If no babysitter was available, several children might come on each trip. If the mother happened to be expecting a welfare check on the date of the clinic visit, she would miss the appointment for fear of having her check stolen.

Population

The total population of the Malcolm Bliss Mental Health Center catchment area is 809,000, 33 per cent black. One-sixth of this population, or 131,000 people, live in the area surrounding the hospital. Forty-three percent of these are black. More than half are 25 years of age or younger. Families average 5 members. One-half of the families live on an income of $6,000 or less. Forty per thousand of the population receive welfare. More than one-half of those 25 or over received 8 years or less of education. The area is known for unemployment, poor housing, high rates of crime, alcoholism and drug abuse.

Medical and dental facilities are inadequate. Children frequently suffer from malnutrition, lead poisoning, birth defects, and untreated chronic diseases. With 43 percent of the population below the age of 17, the schools are overloaded and unable to cope effectively with the large number of problems such as learning disabilities, mental retardation, drug abuse, delinquency, high drop-out rates, unwed mothers and emotionally disturbed children. In general, the description of the Model Cities area must sound all too familiar to those of you working in some of our major cities.

SPACE FOR TABLE I

Table I summarizes the contrast in numbers between the area under study and the total catchment area of the hospital. The much higher rate of registered patients in the area under study shows that in this area, we were able to reach three times as many patients than in the rest of the catchment area. Since Hollingshead and Redlich's (1958) famous study our professional conscience has been jarred repeatedly by reports of the physical as well as mental health hazards associated with being born in a poverty area (Passamanick and Knobloch, 1966; Reissman, 1962; Pavenstedt, et al, 1967).

Program Description

Within the past decade, many types of programs have been initiated to prevent and to solve some of the mental health problems arising from poverty living conditions. Pavenstedt (1971) summarizes very effectively some of these efforts in relation to underprivileged children. No one, as yet, has found the perfect solution or the complete answer. The program described here makes no claim to originality. It's uniqueness, if any, lies in the fact of it's persistence in the face of many adversities.

The Model Cities is divided administratively into 5 neighborhoods, each of which has its own unique characteristics and problems. The neighborhood populations range from 5,500 to 50,000. Three are predominantly black, one is evenly mixed, and one is predominantly white. One of the areas centers around a huge, half empty, defunct housing project built in the 1930's.

The goals of the Outreach Services are:

1. To make mental health services easily accessible to all residents
2. To establish programs with high-risk populations to prevent the development of psychiatric disabilities
3. To educate neighborhood residents about mental health, psychiatric illness, and the various services available to them

Staffing of the 5 neighborhood clinics has been done on a cooperative basis. Malcolm Bliss Mental Health Center was the base hospital from which professional staff was drawn. Paraprofessional staff was recruited from each Model Cities neighborhood, but persons selected had to meet the requirements of the State Employees Merit System. The neighborhood workers had no prior special training in mental health work, and had no responsibilities at M.B.M.H.C., but they knew their neighborhoods and were personally acquainted with many of the persons who would be served by their particular clinic.

The professional staff for each neighborhood center consisted of a full-time social worker who acted as program coordinator, and both an adult and a child psychiatrist who spent the equivalent of one-half to one full day a week evaluating and treating patients in the neighborhood clinics. The physicians were members of the staff of M.B.M.H.C. In addition, one of the authors (E.P.) acted as psychological consultant for all 5 clinics, and played an active role

in training the paraprofessional workers.

Four neighborhood workers were selected in each of the 5 neighborhoods, 2 community assistants to function as assistants to the professional social worker, and 2 psychological technician trainees to assist the psychologist from the MBMHC staff. Each neighborhood clinic also had 2 clerical positions filled by local residents.

The frame of reference under which the neighborhood clinics have operated has followed neither the child guidance model, nor the strict medical model under which the MBMHC Children's Unit functions. When a mother brings her child to the neighborhood clinic, she is met by a worker who lives in the neighborhood. She first registers her child with the neighborhood clinic, not with the center. The social worker and community assistant, sometimes with the help of the psychological consultant, screen the child. If, in their opinion, he presents a "psychiatric problem", he is scheduled to be seen by the physician on his weekly visit to the neighborhood. After his examination of the child, the psychiatrist may recommend treatment and follow-up care.

The question of the criteria used by the community assistants and nonmedical professional staff to determine whether or not a child has a psychiatric problem cannot be answered easily. The decision was influenced by the extent of experience of the staff, the alternate resources available for referring nonmedical problems, and, most of all, the severity of the presenting problem of the child.

The sources of referral for the children in the Outreach area, as compared to the rest of the catchment area of the hospital, are shown in Table II.

There were significantly more referrals by "self and family" and significantly fewer by "social service agency" in the "Area Under Study", than in the rest of the catchment area. This indicates to us that fewer families required formal introduction to the neighborhood clinic and were well enough acquainted with them to go there when they had difficulties with their children.

SPACE FOR TABLE II

Treatment modalities for patients in the Outreach clinics did not differ in any way from treatments used in the out-patient clinic at MBMHC. Medication, psychotherapy, family counseling and consultation concerning appropriate plans for the child at school or at court were the main therapeutic measures used. Long-term intensive psychotherapy was not customarily used at either MBMHC or the neighborhood clinics.

While our computer is still not programmed fully for the Outreach Services and we cannot obtain the information about numbers of missed appointments, it is our impression that fewer patients fail to keep their appointments in the neighborhood clinics as compared to the child out-patient clinic at the Mental Health Center. Families often express great appreciation that the clinics are within walking distance, thereby saving them the time and money involved in a long trip.

A final word also regarding the role of the paraprofessional in the child psychiatric clinics would be appropriate before turning our attention to special services and programs. The demands for service do not permit the child psychiatrists to spend a great deal of their time involved in activities

other than those created by the clinics themselves. Essentially, the feelings, attitudes and characteristics of the community are most directly communicated to the child psychiatrists through their inter-action with the paraprofessionals and the neighborhood-based professional staff. There are many forms this communication takes, some of which are subtle and some of which are not. In some clinics, the community worker joins the psychiatrist when he first sees the child and his mother. In this instance, community workers can provide a great deal of information about the neighborhood, the school the child attends, sometimes the reputation of the teacher he has, or neighborhood perception of the family. Knowledge of the community worker is useful on occasions in helping the psychiatrist in understanding the specific concerns of the parent. For example, one psychiatrist was attempting to understand the mother's insistence that her eight-year old over-active child remain home in their crowded apartment after school, rather than going outside to play. Being informed that the young child had been severely beaten the week before in a nearby abandoned building made the mother's fears more understandable. At times, the communication between community workers and the consulting psychiatrist can become somewhat abrasive. Unlike lower echelon personnel in the hospital, community workers have little hesitation to "tell it like it is". Early in the development of the program, a psychiatrist was discussing a child's alleged problems in terms of long standing emotional strain between the mother and her adolescent son. A paraprofessional vigorously disagreed, indicating her belief that both the mother and child were really asking for help to get out of the nationally notorious high-rise housing project (one of innumerable shootings had taken place the week before). New

housing was found for the family and the boy's symptoms were no longer seen as a problem to either the mother or the son.

Special Services

Considering the close proximity of the Model neighborhoods to one another, the diversity among them is really quite extraordinary. The level of neighborhood organization and resources available differ considerably among the five areas. In some instances, the Outreach Center is one among many existing social and medical programs developed to serve neighborhood residents. In other model neighborhoods, the mental health Outreach Center is one of very few resources available in the community. As a result, the type of individuals referred and the perception of neighborhood needs varies across the five communities. For example, in one large well organized neighborhood with many existing resources, referrals to the child psychiatric clinic are generally typical of those found in most child-guidance clinics. Where the outside network of referring agents tends to screen out non-psychiatrically disturbed clients, families whose primary need is food stamps, legal services, medical attention or companionship rarely find their way into this Outreach Center. In other neighborhoods with fewer resources, the range of presenting problems is considerably greater. A case in which the primary problem was housing has been mentioned. In another instance, a six-year old child was referred to a child psychologist by an interested church group because he wouldn't talk and because the mother was fearful of leaving the immediate neighborhood. Examination of the client revealed a severely retarded, obviously dehydrated youngster, with high fever who had developed a serious respiratory problem and daily convulsions. The child was taken to the emergency room of a children's hospital and admitted for treatment. In

another neighborhood, when the Outreach program was first started, there was some difficulty in renting a facility for the Outreach staff who were housed temporarily in the over-crowded quarters of a local settlement house. Because there was no space to establish clinical services, the staff spent their first months helping clients getting to and from the hospital, offering a wide range of social services and working with the neighborhood group that was attempting to establish shuttle-bus service for residents in need of medical or social services available only outside the area. While this Outreach Center is now housed in different quarters and the clinics are fully operational, there remains a tendency for the staff to involve themselves in a variety of problems not usually dealt with by most child psychiatric clinics. The deep commitment of the Outreach staff to the surrounding community provides an activist orientation to treatment efforts. A more exotic example of our work with individual families is seen in the following case:

> "A youngster new to the neighborhood was referred by the school because he slept a great deal in class and seemingly enjoyed kicking other children with his "boondockers"--a rather lethal pair of shoes. It was discovered that both the mother and father had multiple psychiatric hospitalizations in St. Louis and around the country. Two children were retarded and the oldest son was continually running away from home and getting into trouble with the law. Each time the boy managed to get into some sort of trouble, the mother became even more depressed than usual and often attempted suicide.
>
> This family depended upon four agencies for their income and a good deal of time was spent trying to untangle the financial arrangements. The parents received outpatient care in our adult psychiatric clinic. Because of the severe disability of the mother, a homemaker was found whose services eased the family situation considerably. The two retarded children joined our special activity group

and responded well. The eldest son refused treatment but at our suggestion went to live with relatives during the week, coming home only on weekends. A good deal of his "acting out" stopped which relieved the mother of some of her symptoms. A behavior modification program initiated in the school reduced the kicking behavior of the child who initially brought his family to our attention. The teacher reported that the child had made dramatic gains and she was very pleased with the result. The boy responded well to modified play therapy.

In the midst of our self-congratulations, all hell broke loose! The mother was hospitalized for taking an overdose of drugs. The father stormed the principal accusing him of "favoring" other children whom he said were picking on his son. Our child patient began to miss a great deal of school. The father also severed all contact with the Outreach Center. One of our paraprofessionals who lived near this family reported that the windows of the house were suddenly boarded up, that the children were no longer seen playing outside and that the father had been observed in his yard with a gun in his hand. Further contact with neighbors revealed that the father and another man were seen fighting and cursing in the street.

A home visit by staff members was made with some anxiety. Initially the father would not allow us inside the house, claiming that we were "all against" him and his family. Conversing through a crack in the door, we learned that this man became terribly agitated and distraught when a new neighbor had moved in across the street. Apparently the legendary feuds reported to occur in the Missouri Ozark Hills are not so legendary after all. For two decades, our young client's family had been feuding with the family that inadvertently moved across the street from them. Although our client's family had not lived in the hills for over twelve years, the old animosities and corresponding response patterns started immediately.

We are not certain what others might have done in this situation, but the Outreach staff decided to

> try to negotiate a truce between the two families. After considerable talking and persuading, we finally managed to get the families to agree to certain ground rules that would allow them to co-exist more or less peacefully. While the families would never agree to sit down with one another face-to-face, a written document was signed by both parties. The boards were taken off the windows of our client's house, the children were allowed to play outside, clinic appointments were kept, the behavior of our young client in school became acceptable. The family situation stabilized for several months at which time the family suddenly moved to Arizona, allegedly because of the father's cough. Our regards to the State of Arizona!

Although a somewhat extreme example, as we see it this case represents rather nicely the activist role of the community mental health worker. This family was known to us for a period of fifteen months. During that time, a seemingly endless number of agencies were contacted. A variety of services and treatment modalities were offered the family. Direct efforts were made to intervene within the context of the family, the school, and the neighborhood. While we never entertained the hope that this family would achieve "normality", nevertheless we were quite satisfied with the rather small gains we were able to make.

Treatment Oriented Groups

In addition to direct services provided to individuals, there has been a strong push to establish treatment as well as preventive programs not ordinarily found in most traditional psychiatric facilities for children. While the distinction between treatment and prevention is not sharply drawn, especially so far as children's services are concerned, we tend to regard a treatment program as one which is directed toward a group of persons with

some common problem as defined by the individual or the society in which he lives. A number of such programs have been initiated by the Outreach staff in collaboration with community groups and a variety of methods have been tried. Let us start with those that we have struggled with unsuccessfully.

Efforts to establish programs in two broad areas have been disappointing in spite of strenuous efforts to make them succeed. First, we have attempted in almost a dozen instances to establish groups for parents of children with certain types of disability. We have attempted to establish groups for mothers of hyperactive children, mentally retarded children, children with conduct disorders and disabled child readers. In addition, two preventive groups have been attempted for parents of adolescents and parents of preschool children. Leaders have ranged from highly skilled staff who specialize in leading groups to neighborhood residents (paraprofessionals) supervised by professional staff. The groups have been open-ended as well as time-locked. Some groups have been oriented toward general topics (e.g., communication workshops, parent-child relationship) while others have focused upon the sharing of specific techniques designed to alleviate certain kinds of difficulties (e.g., remedial reading procedures, behavior modification techniques for home use, and the like). Some groups have met at the clinic, some at the school, and some in the homes of the parents.

It has not been possible to evaluate the effectiveness of these groups upon the functioning of families and children simply because we were never able to keep the groups together for any length of time. Attendance has been poor and usually dwindles to one or two regulars. We do not know why our

efforts have failed. The most common complaints by parents are that the group takes time and that talking doesn't do any good. Even though advised differently from the beginning, many parents have strongly expressed the wish to have someone tell them "exactly" what to do when certain difficulties arise in the home.

A similar discontent is found in a second type of program that has not succeeded so far. The burgeoning literature in school consultation testifies to the interest in this area. All but two Outreach Centers have attempted to develop consultation services within the local schools. None has really succeeded. Generally, the school principal is approached and told of the services that are available. He is asked if he would like a mental health team to come to his school to meet with his teachers once a week. All of the principals have agreed that the need is great and have extended an invitation to the Outreach staff. While efforts have been made to discuss general topics concerning mental health of children, teachers almost invariably wish to speak about specific youngsters. They request detailed advice about how they should handle individual behaviors of individual children. Efforts to elicit more information about a particular child from one teacher tends to bore the other teachers in the group. Attempts to discuss ways in which an entire classroom could be "engineered" for purpose of decreasing the amount of disturbing behavior is generally met with a remark, "we aren't allowed to do that".

We tend to agree with others who have noted that a viable school consultation program demands considerable professional time, much preparation and the full support of the top school officials. While the efforts of school consultation have not been very successful to date, a very positive relation-

ship has developed between the community mental health staff, the school principals, the teachers, and school social workers. When interacting with these people, we are very frank about the limits of our expertise and indicate our reliance upon the school as a helping partner. In working with individual children known to us through the Outreach Centers, we have experienced excellent cooperation in most instances and have sometimes been able to achieve striking results by working with the teacher and an individual child.

More successful have been programs developed for specific groups of children. While several such programs are now in operation, we will discuss two which we feel are representative and somewhat unusual.

The earliest and possibly most successful effort at program development involved a group of young, black unwed mothers. One of our paraprofessional community workers originated this project several years ago. Since 51% of the newborn in this particular area are illegtimate, the problem appeared a reasonably serious one for the neighborhood. As an unwed mother herself, the community worker felt that most pregnant unwed adolescents were in need of a supportive group experience, especially since the St. Louis Public School System, at that time, excluded pregnant girls from their regular classrooms. While these girls were able to attend a special school, many of their contacts with peers were severed and many dropped out of the educational mainstream. Considerable strain was often placed upon the parent-child relationships, and there was a tendency for the girls to withdraw and stay at home during the period of their pregnancy. In addition to personal support, the goals of the program were: a) prevent additional unwanted pregnancies, and b) to prevent the child from discontinuing her education.

Fifty girls asked to join the program initially but only 15 were taken into the group the first year. This group met weekly for about two hours. They adopted various tasks to do, discussed their boyfriends and families, invited a nurse to talk about caring for babies, learned about contraceptives, spoke of child rearing, and the like. Embedded among these more concrete activities were discussions of their feelings and attitudes. The group morale was excellent. After one year it was found that all the girls had continued their education and only one unwanted pregnancy had reoccured. The program proved so attractive that the community worker was asked to join forces with the St. Louis Board of Education and assist in their special school program for pregnant girls. She and two members of the first group who demonstrated leadership qualities now work with approximately 200 girls once a week. Currently, the expanded project is now in the process of an extensive evaluation. The results so far look very encouraging.

A quite different program was begun one summer in another neighborhood. Noting that a great number of referred children had severe reading difficulties, the mental health team spoke to local schools and a parents group about the possibility of initiating a summer remedial reading program. The response was enthusiastic and the local school offered to provide the Outreach Center with three classrooms over one summer. An educator from the Center agreed to recruit and train volunteer teachers who, in turn, were to work with mothers of disabled child readers. The educator is a specialist in remedial reading and has developed a beautifully simple and logically sequenced program format which she has used successfully with many mothers of our child psychiatric outpatients. Six suburban teachers agreed to learn the

technique and to work with the mother-child dyads. As we noted previously, attendance by the mothers was poor. Only one mother stuck with the program the entire twelve weeks. The volunteer teachers labored diligently in hot classrooms with thirty-two children (about 50% of whom were clients of the Outreach Center). The reading skills of the children were shown to improve significantly with instruments based upon material covered in the tutoring. Unfortunately, the results of another reading achievement test suggested that the skills had not generalized over this short period of time. We nevertheless considered this project highly successful for three reasons. First, the neighborhood parent group was so pleased with our demonstration project that they voted to establish a similar classroom within their community school program funded by Model Cities money. Second, the tutorial program was modified and run again with the help of a local business which agreed to pay low-income mothers a small stipend for working in the project with their children. Within this format, the participation of the mothers was extremely good. Significant improvement in reading proficiency over eighteen weeks was demonstrated on several reading achievement tests. And, third, the experience of the volunteer suburban teachers motivated them to contact the Outreach Center a few months later to see if their school district could be of any assistance. As a result of this contact, the children in the more wealthy schools voted to give Christmas presents to, and a large party for all of our child clients. Over one-hundred children attended and thoroughly enjoyed the party. A very valuable contact between our Outreach Center and a large suburban school district was thus established.

Programs Oriented Toward Prevention

As noted earlier, once we go beyond the theoretical level to practical application, we find it increasingly difficult to make a firm distinction between preventive and treatment programs. When dealing with children, in a sense all psychiatric treatment can be considered preventive in nature. The unwed mothers and remedial programs would certainly qualify as preventive programs in the thinking of some people. Although several of our Outreach staff members consult with a variety of Day Care and Headstart Centers, demands on their time have usually involved requests for help with specific children who are already manifesting behavioral or developmental deviations. Our staff have also served as consultants to a neighborhood leadership training program and the Neighborhood Youth Corps. A bi-racial group of young adolescent leaders in a "divided" neighborhood is also considered preventive in nature. A language home stimulation program is in the process of development for children age six months to four years. Three neighborhoods have activity groups which involve neighborhood children not in need of psychiatric treatment.

SUMMARY AND CONCLUSIONS

Malcolm Bliss Mental Health Center, through the Outreach Service, provides psychiatric care for the residents of the Model Cities area of the City of St. Louis. The program was started 3 years ago, but was actually in full operation for about 1½ years. The services to children are a part of the total program and it is difficult to separate them out without speaking about the rest of the program.

To evaluate the program like the one described is a thankless task. Success and failure are ill-defined words in themselves, and become even more so when we try to apply them to a mental health program. In terms of the goals we

set for ourselves (see page 4), we successfully established the five clinics in the areas and we are reaching a higher percentage of the population there when compared to the rest of the catchment area. We have started some preventive programs and continue to work on the education of the neighborhood residents with some success, as is evident from Table II. These programs are even more difficult to evaluate and only long-term studies will probably give us the answer about our success or failure in this respect.

We cannot conclude without mentioning one of the main obstacles we experience in our work. The problems connected with mental health and mental disease have a rather low priority for the poverty stricken residents of the inner city. Jobs, housing, and racial issues are very high on the list. It is not always easy to generate enthusiasm about the program among the residents as long as these great issues remain unsolved.

REFERENCES

HOLLINGSHEAD, A. B. & REDLICH, F. C. (1958), Social Class and Mental Illness, A Community Study. New York:Wiley.

PASSAMANICK, B., & KNOBLOCH, H. (1966), Retrospective Studies on the Epidemiology of Reproductive Casualty: old and new. Merrill-Palmer Quart. Behavior, Dev. 12:7-26.

PAVENSTEDT, E., (1971), Psychiatric services for underprivileged children. In: Psychiatric Care of the Underprivileged, ed. G. Belsasso. Boston: Little,Brown

PAVENSTEDT, E., MALONE, C., MATTICK, I., BANDLER, L. (1967), The Drifters: Children of Disorganized Lower-Class Families. Boston:Little, Brown.

REISSMAN, F. (1962), The Culturally Deprived Child. New York:Harper & Rowe

TABLE I

	AREA UNDER STUDY	TOTAL CATCHMENT AREA
Population		
Under 17 years	46,000	286,000
Over 17 years	85,000	523,000
Total	131,000	809,000
Registered patients per 1,000 population		
Under 17 years	15,4	5,8
Over 17 years	50,0	19,2
Total	37,6	14,4

TABLE II

SOURCE OF REFERRAL

	AREA UNDER STUDY	REST OF THE CATCHMENT AREA	TOTAL
Self and family	37%	25%	28%
Friends	1 %	1%	1%
General Hospital	11%	8%	9%
Social Service Agency	9%	15%	13%
Court	4%	8%	7%
School	23%	18%	20%
Other	15%	25%	22%
Total	100% (577)	100% (1374)	100% (1951)

$X^2 = 68,27$
D. F. 6
$P = < 0.001$

MAP
ST. LOUIS CITY AND COUNTY